PHYSICAL FITNESS & MEDICAL HISTORY FORM

THIS FORM IS VALID FOR 2 YEARS FROM THE DATE OF THE DOCTOR'S SIGNATURE.

No other forms are acceptable. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, nurse practitioner, etc.). Section II is modified or substituted ONLY to comply with local and/or state laws or medical practitioner regulations (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to any modified/substituted form.

Section I: For Parent/Guardian Completion Only.

Legal Name of Participant (MUST match birth certificate):

Last: _____ First: _____ Middle: _____

Also known as: _____ Date of Birth: _____ Gender: ❑ M ❑ F

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Sport: ❑Football / ❑Cheer

Medical Insurance Company: _____ ID Number: _____

Name of Primary Insured: _____

Does participant have Medicaid? ❑ Yes ❑ No Does participant have Medicare? ❑ Yes ❑ No

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Participant Medical History:

1. Does the participant have any injuries requiring medical attention? ❑ Yes ❑ No
2. Are there any past surgeries or scheduled surgeries? ❑ Yes ❑ No
3. Is there any history of concussions and/or head injuries? ❑ Yes ❑ No
4. Is the participant currently under the care of a medical practitioner? ❑ Yes ❑ No
5. Is the participant currently taking any medications? ❑ Yes ❑ No
6. Does the participant have any allergies (penicillin, bee stings, etc)? ❑ Yes ❑ No
7. Does the participant have asthma/require the use of an inhaler? ❑ Yes ❑ No
8. Is the participant diabetic/require medication for diabetes? ❑ Yes ❑ No
9. Does the participant carry sickle cell trait/suffer from sickle cell disease? ❑ Yes ❑ No
10. Does the participant currently require medication? ❑ Yes ❑ No
11. Does/has the participant have/had seizures? ❑ Yes ❑ No
12. Does the participant wear glasses or contact lenses? ❑ Yes ❑ No
13. Does the participant wear a brace or other medical support device? ❑ Yes ❑ No
14. Does the participant have any other physical limitations or medical conditions? ❑ Yes ❑ No

If you answered Yes to any of the questions above, please provide the question number and an explanation below or attach to this form:

_____

_____

_____

If you answered Yes about concussions, please provide the name of the doctor or medical professional who cleared Participant for this activity: _____

I certify that this information is accurate. I understand that this medical authorization may be voided in the event of injury, illness or accident and my child may not be cleared for participation at such time. Further, I acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condition of my child. I also understand that it is my responsibility to obtain written permission from my child's physician on official medical stationary in order for my child to resume participation after any and all such injury, illness or accident.

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Printed Name: _____ Relationship to athlete: _____

Section II: This section must be completed by a licensed medical professional.

Please check the box next to each option if healthy or note otherwise.

❑Height _____	❑Weight _____	❑Eyes _____
❑Ears_____	❑Mouth _____	❑Nose & Throat_____
❑Respiratory _____	❑Cardiovascular_____	❑Neurological _____
❑Musculoskeletal _____	❑Dermatological_____	❑Blood Pressure _____

I hereby certify that I am a licensed state examiner and have examined the above named individual and understand that he/she will be participating in Inland Northwest Youth Football or Cheer League programs. I hereby attest that this individual is physically fit and has no medical condition which would prevent this individual from participating in activities for the 2021 season. I am therefore clearing this individual for athletic participation without limitation.

Please indicate Medical Profession (M.D., D.O, R.N., etc) _____

Are you licensed in your state to perform physical examinations? ..... ❑ Yes ❑ No

Today's Date: _____

Please sign and complete the following information or place Official Medical Practice Stamp:

Signature: _____ Printed Name:_____

Address: _____

City: _____ State: _____ Zip:_____

Phone Number: _____ Fax Number:_____

Email/Website: _____

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